CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RUIL DING 00		00	COMPLETED	
		155755	A. BUILDING B. WING		04/08/2011		
		l .		TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	3	- 1		DEGLEIN ROAD		
GOLDEN	YEARS HOMEST	EAD			VAYNE, IN46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)		DATE
F0000							
	This visit was fo	r the investigation of	F000	۱ ۱	The creation and submission of	of	
		•	1 1000	۱	this Plan of Correction does no		
	Complaint Num	ber IN00087424.			constitute an admission by this		
					provider of any conclusion set		
	1 ^	ber IN00087424-			forth in the statement of		
	Substantiated, St	tate/Federal deficiencies	1		deficiencies, or of any violation	n of	
	related to the alle	egation are cited at F223,	1		regulation. This Plan of		
	F333, and F514				Correction is prepared and submitted because of		
					requirements under State and		
	Survey dates: Ap	oril 7 8 2011			Federal law. This provider		
	Burvey dutes. 71	7, 0, 2011			respectfully requests that the		
	F 11', 1	000202			2567 Plan of Correction be		
	Facility number:				considered the Letter of Credil	ole	
	Provider number				Allegation and requests a Pos		
	AIM number: 10	00287520			Survey Review on or after Apr 27, 2011. This provider further	il	
					respectfully requests a desk		
	Survey team:				review in which our		
	Ann Armey, RN	- TC			documents for verification		
	Diane Nilson, R	N			of compliance are being delivery via USPS to Ms. Kim Rhoades		
	Census bed type						
	SNF/NF: 106	•					
	Total: 106						
	10161. 100						
	Census payor ty	ne:					
		μς.					
	Medicare: 8						
	Medicaid: 79						
	Other: 19						
	Total: 106						
	Sample: 8						
		a					
		es reflect state findings					
	cited in accordar	nce with 410 IAC 16.2.					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	[TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JJ3R11

Facility ID:

000282

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155755		(X2) MU A. BUIL B. WING	DING	00	(X3) DATE: COMPL 04/08/2	ETED	
	PROVIDER OR SUPPLIER		•	3136 G	ADDRESS, CITY, STATE, ZIP CODE OEGLEIN ROAD NAYNE, IN46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ompleted on April 14, lkner, RN		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0223	verbal, sexual, phycorporal punishmes seclusion. The facility must in sexual, or physical punishment, or inversal abuse involved 1 of 2 second investigated for a (Resident #G) result of the clinical reconstruction of	roluntary seclusion. ew and record review, the assure a resident was free e. This deficiency taff persons (CNA #10) alleged abuse for 1 of 2 sidents in a sample of 8. The record review, the assure a resident was free e. This deficiency taff persons (CNA #10) alleged abuse for 1 of 2 sidents in a sample of 8. The record review, the assure a resident was free e. This deficiency taff persons (CNA #10) alleged abuse for 1 of 2 sidents in a sample of 8.	F0:	223	F 0223It is the practice of this provider to ensure residents he the right to be free from verba sexual, physical, and mental abuse, corporal punishment, a involuntary seclusion. This provider does not allow verbal mental, sexual, or physical ab corporal punishment, or involuntary seclusion. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? There were no negative outcomes for the resident alleged to have be affected by the deficient practice to be affected by the potentiat to be affected by the same deficient practice and what corrective action will be take The employee was immediate.	I, and I, use, een ce. al	04/26/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155755 04/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3136 GOEGLEIN ROAD **GOLDEN YEARS HOMESTEAD** FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE resident had severe cognitive impairment terminated therefore no other residents had the potential to be and required extensive assistance for affected by the alleged deficient transfer, dressing, hygiene and toileting. practice. What measures will be put into place or what systemic On 4/8/11 at 3:00 p.m., Resident #G changes you will make to ensure that the deficient responded "no" when asked if she had any practice does not recur? This concerns about the way she was treated. provider's system is as follows: -Pre-employment interviews are A facility incident reporting form, dated conducted -Pre-employment reference checks are conducted 3/3/11, was reviewed on 4/8/11 at 3:05 -Employment criminal p.m., and indicated Resident #G's background checks are daughter reported she overheard CNA #10 completed -Employees are yelling at her mother in the bathroom. The trained upon hire and routinely thereafter on abuse and neglect incident report indicated Resident #G policy and procedure -Proper stated that CNA #10 "was mean" to her. authorities are notified of abuse The report indicated, Resident #G was and neglect allegations -This examined, after the incident and the provider has a zero tolerance for abuse and neglect, therefore any employee was suspended. The report allegations of such incidents will further indicated the Indiana State warrant immediate termination. Department of Heath was notified and How the corrective action(s) following an investigation, CNA #10 was will be monitored to ensure the terminated. deficient practice will not recur, i.e., what quality assurance program will be put into place: The termination notice, dated 3/4/11, was All staff were in-serviced by the reviewed on 4/8/11 ay 3:10 p.m., and Administrator and/or Director of indicated "On 3/3/11 at 7pm, (Resident Nursing Services or #G's initials) daughter reported above designees between March 4-March 20, 2011 regarding this name employee (CNA #10) was yelling at provider's abuse and neglect her Mother while assisting her in the policy and procedure, caring for bathroom...This matter was thoroughly combative residents and resident investigated and it was substantiated rights. Administrator or designee will monitor continued compliance employee was verbally abusive to through monthly random resident....employee is being terminated employee interviews regarding for violating nursing home standards and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S COMPLI		
AND PLAIN	OF CORRECTION	155755		LDING	00	04/08/20	
		100700	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 11 00120	
NAME OF F	PROVIDER OR SUPPLIER				OEGLEIN ROAD		
GOLDEN	I YEARS HOMESTE	EAD		1	WAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
IAG		usiness conduct policies	+	IAG	our abuse and neglect policy x	(6	DATE
	in regards to: Res	•			months. The Administrator wil		
	in regards to. Re.	sident Abuse.			document findings on a Quality		
	On 4/8/11 at 3·1·	5 p.m., the Director of			Improvement Tool and report t results of this audit to the Qua		
		ed CNA #10 had been			Assurance committee who will		
	terminated for ve				determine the frequency of		
					further audits.		
	Inservice reports	were reviewed on 4/8/11					
	at 3:20 p.m., and	indicated, after the					
	incident, all emp	loyees were inserviced,					
	between 3/4/11 a	and 3/20/11, on					
	abuse/neglect, ca	ring for combative					
	residents and resi	ident rights.					
	The policy for Dr	revention of Resident					
		ect, dated 7/12/10,					
	_	Director of Nursing, was					
		11 at 3:30 p.m., and					
		resident living in this					
		he right to be free from					
		d misappropriation of					
	their property	** *					
	1 1 2	s defined as the use of					
	oral, written, or g	gestured language that					
	willfully includes	s disparaging and					
	derogatory terms	to residents or their					
	families"						
	_	relates to Complaint					
	Number IN0008'	/424.					
	3.1-27(b)						
	5.1 27(0)						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155755		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/08/2	ETED	
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD			р. үн	STREET A	DDRESS, CITY, STATE, ZIP CODE DEGLEIN ROAD VAYNE, IN46815	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	Nurse Leader #1 contacted the pharmacy indicated 30 capsules, was only box prior to October, 2010. Community Nurshad audited the march, 2011, and no Spiriva for Remedication cart at pharmacy at that the last time the in October, 2010. At 4:10 p.m. on a indicated, althout Report, dated 3, physician was not discovered and the discontinued, the been discontinued the physician had wanted the medicated a daily basis. Review of the Mindicated the Spit given daily at 6:00.	counted, and the ted the box of Spiriva, sent on 3/23/11 and the 3/23/11, was sent in se Leader #1 indicated he nedication carts in d discovered there was esident #H in the and contacted the time, and was informed Spiriva was ordered was					

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155755		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP:	LETED	
	PROVIDER OR SUPPLIER		STREET A 3136 G	ADDRESS, CITY, STATE, ZIP COI OEGLEIN ROAD NAYNE, IN46815	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERNCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	Review of the M indicated the Spi given at 6:00 a.m and 8, 2011. Therefore, altho on the MAR for indicated the med 15 times since M was re-ordered, missing from the 3/23/11.	AR for April, 2011, riva had been initialed as a., on April 1, 2, 4, 5, 6, 7, ugh initials documented March and April, 2011, dication had been given farch 23, 2011, when it only 6 capsules were medication box sent on relates to Complaint	TAG	DEFICIENCY)		DATE
F0514	each resident in a professional stand complete; accurat accessible; and sy	naintain clinical records on ccordance with accepted lards and practices that are ely documented; readily stematically organized.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155755	B. WING 04/08/2011			011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			l	OEGLEIN ROAD		
GOLDEN	I YEARS HOMESTE	=AD		l	NAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ntify the resident; a record of essments; the plan of care					
		ided; the results of any					
		eening conducted by the					
	State; and progres						
SS=D	Based on observa	ation, record review, and	F0	514	F514It is the practice of this		04/26/2011
	interview, the fa	cility failed to maintain			provider to maintain clinical		
	clinical records the	hat were accurately			records on each resident in accordance with accepted		
		ursing staff documented			professional standards and		
		n of a medication when			practices that are complete;		
		ad not been re-ordered			accurately documented; readil	у	
					accessible; and systematically	,	
	•	ths and then once			organized. The clinical record		
		ot administered routinely			contains sufficient information		
	but was initialed	_			identify the resident; a record of		
	deficiency affect	ed 1 resident, Resident#			the resident's assessment; the plan of care and services	;	
	H, in a sample of	f two residents reviewed			provided; the results of any		
	for medication er	rrors.			preadmission screening		
					conducted by the State; and		
	Findings include				progress notes. What corrective	ve	
	1 mamgs merade	•			action(s) will be accomplishe	d	
	1 Daview of a N	Andination Eman Donast			for those residents found to		
		Medication Error Report,			have been affected by the		
		dicated Spiriva 18			deficient practice? No negative		
		g), handihaler, one puff			outcomes occurred as a result	OT	
	every day at 6:00	a.m. was ordered to be			our alleged deficient practice. Resident H: A medical		
	given to Residen	t #H.			assessment was completed or	,	
	The report indica	ited an error was made			3/23/11 with no negative	•	
	between Novemb	per 2010 and March,			findings.Resident H: The Spiri	va	
		of error indicated, "failure			order was discontinued per far		
	. –	cation" and the reason			physician on 4/12/11. How wil	ı	
	•	ot reorder medication as			you identify other residents		
	needed. "	ot reorder medication as			having the potential to be	,	
		0.1			affected by the same deficier		
	-	of the error indicated the			practice and what corrective action will be taken? A 100%		
	medication was i	•			resident Medication		
	(between Novem	ber 2010 and March			Administration Record audit w	_{as}	
	2011). However	, the Pharmacy indicated			Samuel Substitution of Guardian		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED	
		155755	B. WIN			04/08/2011	
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OEGLEIN ROAD		
GOLDEN	YEARS HOMEST	FAD		1	VAYNE, IN46815		
			_				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG		DATE	
		ad not been re-ordered			completed on 4/11/2011 with r further residents receiving	10	
	since October 9,	2010.			Spiriva. What measures will be	20	
	An audit of the r	nedication cart,			put into place or what system	I	
	completed 3/23/	11, revealed the			changes you will make to		
	medication was	not in the medication cart			ensure that the deficient		
	and was re-order				practice does not recur		
		ction taken indicated,			-Interdisciplinary team will mee	et	
					Mon-Fri excluding holidays to		
		tion to nurses involved.			review each physician's order		
		ed and medication			we can immediately identify ar	•	
	discontinued. "				new Spiriva orders. All License	∌d	
					Nurses were trained on the		
	The clinical reco	ord of Resident #H was			following by the Director of Nursing Services or designee	on	
	reviewed on 4/8/	/11 at 2:05 p.m and			4/18-4/20/2011:-Re-ordering		
		ident had diagnoses			medications policy and		
		out were not limited to,			procedure -Spiriva manufactui	rer's	
					insert for proper administratior		
		tive Pulmonary Disease.			was reviewed-Policy & Proced		
		hysician orders for March			for accurately administering ar	nd	
	2011, indicated	-			documenting		
	handihaler, inha	le contents of one capsule			medications -Reviewed the procedure of using a medication	on l	
	orally, once dail	y, at 6:00 a.m.			count sheet when using) I	
	The MAR (Med	ication Administration			Spiriva How the corrective		
	Record) for Mar	ch 2011, indicated the			action(s) will be monitored to	,	
	· · · · · · · · · · · · · · · · · · ·	originally ordered March			ensure the deficient practice		
		vas initialed as given			will not recur, i.e., what quali	ty	
		· ·			assurance program will be p		
	1 -	0 a.m., for the entire			into place? -Director of Nursir	ıg	
	month of March				Services or designee		
		pril, 2011, indicated the			will monitor our pharmacy		
	medication was	initialed as given at 6:00			software for medications reord	er	
	a.m., on April 1	,2,4,5, 6, 7, and 8, 2011.			dates at least monthly x 6 monthsAdministrator or		
	There were no ir	nitials documented for			designee will monitor continue	ed l	
	April 3, 2011.				compliance through monthly	_	
					random MAR audits x 6 month	ıs.	
	At 3:00 n m	1/8/11 accompanied by			The Administrator and/or		
	_	1 4/8/11, accompanied by			designee will document finding	js	
	the Director of N	Jursing Services (DNS),	- 1			I	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155755	B. WIN			04/08/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	ę.		3136 G	OEGLEIN ROAD		
	N YEARS HOMEST				VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	1 ^	lesident #H was observed			on a Quality Improvement Too and report the results of this a		
		n cart in a box. The DNS			to the Quality Assurance	uuit	
	1	sules in the box and 24			committee who will determine	the	
	1 -	ed in the medication box.			frequency of further audits.		
		ted 30 capsules had been					
	sent on 3/23/11,	so 6 capsules were					
	missing from the	e medication box.					
	At 4:05 p.m., or	1 4/8/11, the Community					
	Nurse Leader #1	indicated he had					
	contacted the ph	armacy after the					
	medication was	•					
		ted the box of Spiriva,					
	1 *	s sent on $3/23/11$, and the					
	1 *	3/23/11 was sent in					
	October, 2010.	, 5, 2 5, 11					
	1	se Leader #1 indicated he					
	1	nedication carts in					
		nd discovered there was					
		esident #H in the					
		and contacted the					
		time, and was informed					
	1 *	Spiriva was ordered was					
		•					
	in October, 2010	<i>.</i>					
	At 4:10 p.m. on	4/8/11, the DNS					
	indicated, althou	gh the Medication Error					
	Report, dated 3/2	23/11, had indicated the					
	_	otified after the error was					
	1 " "	he medication was to be					
	discontinued, the	e medication had not been					
	1	he DNS indicated the					
	physician had be	een notified and wanted					
	* '	o be continued on a daily					

000282

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155755		(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011	
	ROVIDER OR SUPPLIER		3136 G	ADDRESS, CITY, STATE, ZIP CO OEGLEIN ROAD NAYNE, IN46815	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	basis. Review of the M indicated the Spi given daily at 6:0 (when it was re-c2011. Review of the M indicated the Spi given at 6:00 a.m and 8, 2011. Therefore, althou on the MAR for indicated the me 15 times since M was re-ordered, missing from the 3/23/11.	AR for March, 2011, criva had been initialed as 200 a.m., between 3/23/11 bordered) and March 31, ariva had been initialed as an., on April 1, 2, 4, 5, 6, 7, angh initials documented March and April, 2011, dication had been given larch 23, 2011, when it only 6 capsules were a medication box sent on arelates to Complaint		CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

I	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 04/08	TE SURVEY MPLETED 3/2011
	ROVIDER OR SUPPLIE		3136 G	ADDRESS, CITY, STATE, ZIP CO OEGLEIN ROAD NAYNE, IN46815	ODE	
GOLDEN (X4) ID PREFIX TAG	SUMMARY : (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)			RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE